FULL TEXT AUTHORS' ACCEPTED MANUSCRIPT

Full title: Police officers' perceptions of their role in a mental health Magistrates' court pathway.

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Abstract

Although common in the USA, Mental Health Courts are relatively new to the UK and their effectiveness here is not yet fully understood. Referral to these courts is largely reliant upon early identification of mental health problems, a task commonly undertaken by police in the custody suite. Little is known about police perceptions of their role in working with offenders with mental health system in the UK. This exploratory study therefore investigates police views of a pilot Mental Health Courts and their role within the pathway to these. Semi-structured interviews were conducted with six members of a large police force involved in a pilot Mental Health Court. Data-led thematic analysis was used to identify the recurrent themes emerging. Three main themes were identified: 'Benefits of a Mental Health Court', 'Police as Gatekeepers' and 'Barriers to Identification'. The introduction of Mental Health Courts in the UK was viewed as being reflective of changes in approaches to criminal justice. Whilst feeling responsibility for referrals to the Mental Health Court, time, training and multiagency working were seen as hindering this. The findings suggest the success of Mental Health Courts is dependent upon 'getting it right' from the start of the pathway; recommendations are provided.

KEY WORDS: Police, Mental Health, Offenders, Court

1. Introduction

Although well established in the United States, Mental Health Courts (MHC) have only been running on a pilot basis in the United Kingdom since 2009. Set up in direct response to the Bradley Report (2009), an independent review on behalf of the government of the experience of people with mental health problems and people with learning disabilities in the criminal justice system, MHCs purportedly offer clear advantages aiming to divert individuals with mental health issues away from the Criminal Justice System (CJS) and towards appropriate support and treatment programmes (Bradley, 2009). MHCs therefore represent a move away from criminalising those with mental health issues, instead working on the basis of Therapeutic Jurisprudence which recognises that the traditional criminal justice system is ineffective in dealing with offenders with mental disorders (Miller & Perelman, 2009; Ryan & Whelan, 2012; Winick, 2003).

Despite their advantages a number of criticisms have been directed at MHCs (Miller & Perelman, 2009; Ryan & Whelan, 2012). It has been argued that MHCs exacerbate the problem rather than solve it, doubly stigmatizing defendants for their mental illness and their involvement in the CJS (Miller & Perelman, 2009). The separation of MHCs from traditional courts has been likened to segregation with the implication that offenders attending MHCs are different from 'typical' offenders (Wolff, 2002).

Further critiques of MHCs have centred on the role of the CJS and the belief that it should focus on serving justice rather than being a social service provider (Miller & Perelman, 2009). Some individuals only gain access to mental health services after

arrest which is argued to be an inappropriate route by which to gain treatment (Seltzer, 2005; Sirdifield & Brooker, 2012; Stefan & Winick, 2005). Finally, the extent to which personnel in the CJS have suitable mental health training has been questioned (Miller & Perelman, 2009).

1.1. Identification of mentally disordered suspects

Whilst practitioners in court recognise they have a responsibility to provide appropriate support for vulnerable individuals there is a general assumption that any special needs will have been identified by other agencies before a case reaches court (McLeod *et al.*, 2010). Identification can positively affect an individual's health and justice trajectories and can determine an offender's pathway through the CJS, such as referral to a MHC (Gur, 2010). In the UK referrals to MHCs can be made by defence solicitors, the court and probation officers but are most often made by the police (Winstone & Pakes, 2010). Indeed, the Bradley Report (2009) recommends that the identification and assessment of offenders should occur at the earliest opportunity, in the police station.

In the UK, up to 20% of suspects passing through police stations are estimated as having mental health needs, with approximately 7% of people remanded in custody having a serious mental illness (Bradley, 2009; Shaw *et al.*, 1999; Sirdifield & Brooker, 2012). Despite this exposure to individuals with mental ill health the police, whilst having some degree of accuracy in identifying mentally disordered individuals (Riordan *et al*, 2000), do not consider themselves to be competent diagnosticians (Green, 1997). Indeed it has been reported that screening in custody suites (a designated area in UK police stations where those arrested are detained and processed) often fails to detect

suspects with serious mental health problems and leaves officers uncertain as to the appropriate referral pathway (McKinnon & Grubin, 2010; Riordan *et al.*, 2000).

The Bradley Report (2009) identifies a number of factors that may contribute to failings in the identification of mental health issues during custody suite risk assessments including: a reliance on self-reporting; the lack of a standard mental health assessment tool; and a lack of police training in mental health awareness. The identification of mental health issues is also a time-consuming task in an already pressured role (Gendle & Woodhams, 2005; Hayes, 2007; McLean & Marshall, 2010; Oxburgh *et al.*, 2016). Whilst such pressure may enable targets to be met (e.g. detainees processed) this can also lead to corners being cut and mistakes being made such as the failure to correctly identify mental health issues (Hellenbach, 2012).

1.2. Criminal justice and mental health interface

Although essentially gatekeepers of both the criminal justice and mental health systems (Watson *et al.*, 2010) police officers may find themselves in a position of role conflict between traditional law enforcement expectations of their role and contemporary social welfare expectations (Fry *et al*, 2002). Scantlebury *et al.* (2017) argue that cuts to mental health services in the UK has led to a reliance on the police being a first port of call for individuals with mental ill health which places strain on an already strained police force. Indeed, despite being a vital contact point police officers have reported that dealing with people with mental health problems is not their responsibility, largely due to feeling inadequately skilled or educated to fulfil this role (Fry *et al*., 2002; Gendle & Woodhams, 2005).

Oxburgh *et al.* (2016) report on the lack of standard mental health training available to police forces in the UK, finding that almost half of the police included in their study had not received any mental health training despite being actively involved in dealing with mentally disordered suspects. This is problematic as failure to recognise and correctly process suspects with mental health problems impacts upon these individuals' well-being and may lead a suspect to be criminalised rather than being diverted towards the appropriate mental health systems (Lamb *et al.*, 2002).

It has also been suggested that some mental health services do not recognise the work that the police do to assist them. In the USA it has been reported that the police feel burdened with inappropriate responsibility for the mentally ill whilst being unfairly criticised by mental health service professionals (Gillig *et al.*, 1990). Interviews with police officers in Scotland indicated that they felt empathy toward the needs of people with MH problems and were aware of the effect that police intervention may have upon them but they also felt that some MH services did not recognise the work that the police do to assist them and, in concurrence with Gillig *et al.* (1990), at times felt criticised by health professionals (McLean & Marshall, 2010). Such tensions are problematic given that inter-agency working is essential for a MHC to be successful.

1.3. Rationale for current study

Although mental health courts are slowly being introduced in the UK research into these courts is scarce and limited to evaluative studies (e.g. Pakes *et al.*, 2010; Winstone & Pakes, 2010). It is also difficult to make direct comparisons with the findings from MHCs in the USA, where they are far more established, as there is no single model of a

MHC. Ryan and Whelan (2012) observe that the MHCs established in the UK vary greatly from their counterparts in the USA. For instance, within the UK persons with a dual diagnosis of MH and substance abuse problems are not permitted to participate in the court unless the primary need is of a mental health nature, whereas in the USA and Canada such persons would qualify (Winstone & Pakes, 2010). Therefore it is important to consider emerging MHCs in the UK in their own right.

Furthermore, how the police view their role at the start of a MHC pathway has not been explored. Indeed, despite the number of suspects entering custody suites with mental health issues in the UK, very little psychological literature has considered police perspectives of dealing with mentally disordered suspects within the UK (e.g. McLean & Marshall, 2010; Oxburgh *et al.*, 2016). The current study aims to readdress this by endeavouring to answer the following questions:

1. What are the police officers' views and experiences of the introduction of a pilot mental health court?
2. How do the police view their role and responsibilities within a mental health court pathway?

2. Method

2.1. Sampling and Participants

The sample was derived via a maximum variation approach to purposive sampling (Morrow, 2005; Patton, 2002), with information rich participants being selected to take part; those from which considerable information about the issues of importance to the purpose of the research could be gained. In this study interviewees were selected due to their involvement in the implementation of the pilot MHC and their experience of working in the police custody suite, thus as part of this role they also had experience of identifying and referring detainees with mental health issues and/or learning disabilities. Of eight eligible members of a Metropolitan police force in the North West of England where the pilot MHC was being introduced, six agreed to take part. Four interviewees were male, two were female, and represented a range of seniority and roles within the force with the sample including a chief inspector, inspector, sergeants and custody detention officers. Guided by the principle of information power (Malterud, Siersma & Guassora, 2016), the sample size was found to be sufficient.

2.2. Design and procedure

Participants took part in semi-structured interviews lasting on average one hour (M = 52.37 minutes, SD = 29.30). Open ended questions were used which focused upon examining participants' awareness and understanding of the MHC and the processes involved in the court pathway, e.g. 'How do people with mental health problems get referred [to the Mental Health Court]?'. The semi-structured interview can be viewed as "a conversation with purpose" (Bingham & Moore, 1959) and affords the flexibility to deviate from the interview schedule to explore interesting avenues that arise, where relevant to the research question. Interviews were digitally recorded then transcribed

using the orthographic method, creating a verbatim representation of the data which focused on what was said rather than capturing the paralinguistic features of how it was said. The transcribed data was analysed using data-led thematic analysis (Braun & Clarke, 2006), facilitated by qualitative data analysis software (NVIVO, v.9). The theoretical freedom of data-led thematic analysis means it is a flexible research tool that has the potential to provide a rich, detailed account of the data (Braun & Clarke, 2006).

The process of thematic analysis involves familiarisation with the data, searching and coding of the text to identify themes within the data, and reviewing and confirming final themes. This process is iterative with earlier stages of the process being returned to where necessary for clarification and refinement. Criteria to ensure trustworthiness and credibility in qualitative research were adhered to, enhancing the scientific rigour of the study (Elliott, Fischer & Rennie, 1999; Morrow, 2005: Patton, 2002). Strategies included secondary coding of the data to enhance the confirmability of the study (Lincoln & Guba, 1985), member checks with participants, contextual grounding to the data in the reporting of the findings and researcher reflexivity.

3. Results

Interviews conducted with the police were analysed in relation to their understanding of the purpose of the MHC and their role in the pathway. Particular attention was paid to issues surrounding identification for the MHC. Three main themes were identified and labelled as ‘Benefits of a Mental Health Court’, ‘Police as Gatekeepers’ and ‘Barriers to Identification’. The themes extracted from the data are described along with emerging subthemes and illustrative extracts.

3.1. Benefits of a Mental Health Court

This theme refers to police positivity regarding the introduction of the MHC with the court being viewed as a beneficial service. All interviewees were clear that the key driver behind the introduction of the MHC was to break the cycle of crime, the recurrence of offending. To do this the causes of crime needed tackling, which was viewed as being a cost effective solution.

> *We see now that it's cheaper and more beneficial if we can prevent someone's behaviour, it's like the old dentist thing, prevention is better than cure. (P3)*

> *We need to be looking at the causes and then some of these causes can be addressed to prevent that person from becoming a problem to us again. In that respect if somebody intervenes with a person and stops them offending it's going to save valuable police time and money. (P6)*

This reflects a shift from a punishment to a rehabilitation approach to criminal justice; a more care based, problem-solving, approach that takes into account individual needs.

> *There's two ways of looking at criminal justice, one is about catching and punishing people. But we're moving away from that now: we're looking at tackling the issues, the causes and addressing them. (P3)*

This change underpins the differences between the MHC and a 'traditional' court:

> *You're not just sending then to court and they're coming away from court with nothing. The idea is that the court realises they need some support and that they get the support that they need. (P2)*

3.2. Police as Gatekeepers in the MHC

The next theme explored how the police view their role the MHC. Interviewees gave very clear and succinct accounts of this, focusing on the procedures carried out in the custody suite with the process of identification being a subtheme here. This theme outlined the key position the police occupy at the start of the MHC pathway.

> *We're the first point of call. We arrest, we do the initial analysis of a person when they're brought in, and we're the ones to make referrals. Our main role is the identification of the people who go to the [mental health court]. (P3)*

> *In a way I'm the initial gatekeeper (P6)*

From this perspective it can be argued that the success of the MHC falls largely on the shoulders of the police in the custody suite. It is they who conduct the assessments, identifying individuals in need of further support, including being directed to the MHC. The importance of their role was highlighted as follows:

> *99.9% of all of your referrals will come from us, from custody. They're depending upon us. (P1)*

3.2.1. The process of identification for the MHC

In describing their role it was outlined that detainees entering the custody suite underwent a standardised risk assessment. It was clear that identification of mental health issues was very much reliant on self-disclosure and it was generally felt that detainees were quite open about their mental health issues.

More often than not they'll tell you that they've got a problem. They won't try to hide it, especially the adults. (P5)

It was clear that it was important for detainees to disclose their mental health problems as without this the custody suite officers were left with limited information on which to make an identification.

If they don't volunteer information you're not going to find out unless their behaviour is such that you think something's a risk (P3)

Apart from [self-disclosure] we have no information at all, we're completely dealing with people blind. The danger with that is people don't always present themselves with extreme mental health issues. (P1)

Despite following the MHC processes, the police were aware that the figures being referred to the MHC were not reflective of the amount of people with mental health issues they came into contact with.

About a third of the people that come in here have some sort of mental health issue, so the numbers are potentially big which aren't reflected in the targeted services numbers. (P1)

We are missing quite a few, we do miss them. (P3)

3.3. Barriers to identification

This theme summarises what the interviewees saw as being the barriers to successful identification. Many highlighted the daily pressures faced by officers in the custody suite. Being in the custody suite was a case of juggling tasks, none of which had clear priority over the other. Directing people to the MHC was an added task in an already time consuming role.

> *The work here is so fast and there's so much of it. If we had a bit more time to think [about identification for the MHC] it'd be a lot easier but we don't, we have so many things flying at us. (P6)*

> *There's lots of people coming through the doors, they're hectic places custody offices, so it's a matter of thinking, right I've got to make sure. But booking people in to the electronic system takes some time. (P4)*

The volume of people being processed through the custody suite was also felt to contribute to missed identifications as staff became accustomed to mental health problems and may conflate behaviour indicative of mental health issues with being an offender.

> *You become acclimatised to the people you work with in the police otherwise you would fall apart. Sometimes you can miss things. You get used to dealing with a volume of people that sometimes you accept as normal what really isn't normal but you've seen it that many times that you just think it's normal. (P3)*

3.3.1. Training Issues

A further barrier all interviewees discussed regarded training. Whilst acknowledging some training had been received in how to identify mental health issues it was not felt that this was sufficient. It was also mentioned that training was focused on procedural rather than identification issues.

> *It can be a bit confusing because people come in and say I'm depressed but really they're depressed because they've been arrested, they're not clinically depressed. But it's a matter of identifying the ones who should really go to the court; that's about training them as staff. (P4)*

> *There's discussions and bits of training around mental health issues but those courses are quite heavy on safeguarding because it's our main aim. (P1)*

3.3.2. Multi-agency communications

Many of the interviewees mentioned the lack of information sharing between the different stakeholders (e.g. probation services, mental health teams, lawyers, magistrates) in the MHC. The focus here was on the lack of a feedback loop within the system. The police, being at the start of the pathway, did not receive information as to what happened further down the pathway to offenders identified for the MHC. They received no feedback with regards to whether their identifications were accurate or what the outcomes were for people who had been referred to the MHC.

> *If we sent somebody to the [MHC] and they got the help they needed and then if we got feedback from the court saying thanks to the efforts of the staff this is what this person is doing now. It's just a blind thing for us now because once*

they've left here, we don't know. If we got more of feedback, I think people would recognise it more to think that person needs that help. (P5)

The lack of feedback from other stakeholder groups was seen as disheartening and it was felt that receiving such feedback would help to reinforce the message of the MHC.

4. Discussion

Viewing the introduction of a dedicated MHC as beneficial the opinions expressed by the police officers in this study reflected principles of therapeutic jurisprudence (Winick, 2003), with the view that punishment is not effective in dealing with people with mental health issues; instead the court was seen to offer an opportunity for support in helping to break the cycle of crime. This perspective reflects the empathy and compassion shown by police in other parts of the UK towards individuals with mental health issues (McLean & Marshall, 2010) and recognition of the valuable role the police have the potential to play in an offender's trajectory through the CJS.

As earlier research has found (Watson *et al.*, 2010; Winstone & Pakes, 2010), the police interviewed in this study viewed themselves as gatekeepers of criminal justice and mental health services being responsible for referrals to the court. However it was acknowledged that many offenders with mental health issues were not being referred with the process of identification of these problems being criticised. It was felt that the standardised risk assessment administered to a suspect upon entering the custody suite remained reliant upon self-disclosure of mental health problems, an issue highlighted as problematic in the Bradley Report (2009). Without this self-disclosure the police interviewed expressed uncertainty in identifying mental health issues, a common picture

with police internationally (Green, 1997; McKinnon & Grubin, 2010; Oxburgh *et al.*, 2016; Riordan *et al.*, 2000). This also leads to uncertainty amongst police in determining the appropriate referral pathway (McKinnon & Grubin, 2010). With doubts being cast over the effectiveness of the standardised risk assessment currently being administered in custody suites in the UK (McKinnon & Grubin, 2010) there have been calls for a standardised universal *mental health* screening tool to be introduced (Noga *et al.*, 2014) which may go some way towards supporting police in the identification of offenders with mental health needs and thus more effective and appropriate referral to MHCs.

Further improvements to this issue may be achieved via better training with regards to mental ill health. The police interviewed in the current study indicated that where training did occur it focused largely on procedural rather than identification issues. Indeed, literature suggests that within the UK there is a lack of adequate training of police officers with regards to mental health problems. Training programmes have focused on a variety of issues including but not limited to understanding of, raising awareness of and identification of mental health issues (both broad and specific) and/or of intellectual disabilities (see Booth *et al.*, 2017). However where training does occur this varies considerably and is mostly online (Booth *et al.*, 2017; Noga *et al.*, 2014; Scantlebury *et al.*, 2017). Whilst there is a need for improved mental health training for the police in order to improve the functioning of MHCs, Booth *al.'s* (2017) systematic review of the effectiveness of mental health training programmes for non-mental health trained professionals, including the police, indicates that it is at present unclear as to the form this training should take.

What is clear is that any training should be inter-professional and experiential (Booth *et al.,* 2017; Hean *et al.*, 2009). Inter-professional training is important as it offers the potential for each profession to understand the others organisational culture (Booth et al., 2017). In support of this, Scantlebury *et al.* (2017) report on a specialised mental health training programme for frontline police officers delivered by mental health professionals which aims to enhance understanding of and ability to identify mental ill health, record this information, and to respond and refer vulnerable people appropriately. Their evaluation of this programme indicated a potential positive effect in terms of police recording practices for individuals with mental health problems; a vital step in referral to MHCs. Furthermore, after delivering such training mental health professionals report having a better understanding of the role of the police and the pressures that they face in their role (Forni, Caswell & Spicer, 2009).

Such inter-professional understanding of one another's roles is an important step in breaking down barriers between justice and health agencies, an area of tension that has been identified in previous studies of pilot MHCs in the UK (Winstone & Pakes, 2010). In the current study, police officers reported that when they did identify offenders with mental health problems and diverted them to the MHC they were uncertain of their success here, unware as to whether they were correct in their identification and of the outcomes for the offender in the MHC. Such lack of feedback may lead to the perception, as held by some police officers elsewhere in the UK, that their work with mentally disordered offenders is not recognised by mental health services (McLean & Marshall, 2010). Therefore it is important that all agencies involved in a MHC pathway have clearly defined roles and responsibilities in the pathway, and communicate effectively sharing news of offender outcomes. This in turn offers the opportunity for

positive reinforcement which can be motivating and can help increase police officer performance (Anshel, 2000; Brewer *et al.*, 1994).

4.1 Limitations

This study gives an insight into how police view their position at the start of the pathway to a MHC, identifying barriers to the court's success. Although the number of participants was limited, information power was sufficient (Malterud *et al*., 2016). Hence, the expertise of the interviewers and amount of verbal data they elicited from the interviews (over 5 hours of material) and the richness of this data in relation to the narrow study aim and the specific sampling of participants – those members of the police force who had been involved in the implementation of the pilot MHC - led to a sample size of six participants being appropriate for an exploratory thematic analysis. However a full understanding of how a MHC works cannot be established from a single stakeholder group; others may hold different views and identify different barriers to success (e.g. McNiel & Binder, 2010). Therefore further studies are needed to understand how different stakeholders view their roles and responsibilities in MHC pathways; doing so will help maximise the success of new MHCs. Nevertheless, focusing on the views of one stakeholder group allows for an understanding of the specific issues they see as important which can be highlighted and addressed from an individual practice perspective.

The pragmatic reality of implementing processes to support the MHC pathway for the police involved was somewhat removed from the ideological benefits of the MHC pathway, which interviewees strongly supported. This highlights the importance of practice and process research work in highlighting the pragmatic, interpersonal, cultural and organisational factors that can influence the effectiveness of initiatives such as a

MHC. Without evaluations of pathways and initiatives such as this being conducted we are unlikely to know why things work or why they fail and, crucially, whether the goal of reducing reoffending is actually being met.

4.2 Conclusions

Whilst questions have been raised as to whether the identification of mentally disordered offenders should be the role of the police (Miller & Perelman, 2009), cuts to mental health services in the UK in recent years have exacerbated the issue creating a situation where the police have this additional role to fulfil. The findings of this study concur with previous studies regarding how the police view their roles and responsibilities when dealing with offenders with mental health problems and add to the scarce literature that considers this from the perspective of the police in the UK. Furthermore, unlike previous studies, the current study applies these findings to the context of a MHC and the pathway to this, demonstrating that though the MHC pathway was supported, identification and training issues can impede MHC implementation.

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